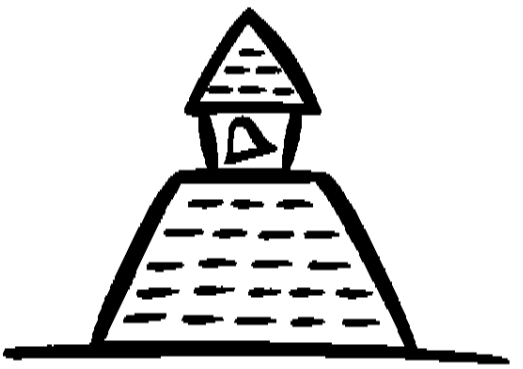
EXHIBIT B

KINDERCARE LEARNING CENTERS, INC.



KinderCare®

Copayment Plan
Preferred Provider Plan
Major Medical Plan
Dental Plan
Vision Plan

PLAN BOOKLET

Regence BlueCross BlueShield of Oregon
PO Box 1271
Portland, OR 97207-1271
www.or.regence.com

To: All Eligible Employees

Welcome to membership in the group health plan provided for **you** and **your** dependents by KinderCare Learning Centers, Inc. KinderCare Learning Centers, Inc. has chosen Regence BlueCross BlueShield of Oregon to provide **your** health care plan.

Employer Paid Benefits
Your health coverage plan is a self-funded benefits plan administered by Regence BlueCross BlueShield of Oregon. This means that KinderCare Learning Centers, Inc., not Regence BlueCross BlueShield of Oregon, pays for **your** covered medical services and supplies. **Your** claims will be paid only after KinderCare Learning Centers, Inc. provides Regence BlueCross BlueShield of Oregon with the funds to pay **your** benefits and pay all other charges due under the **plan**.

Because of their extensive experience and reputation of service, Regence BlueCross BlueShield of Oregon has been chosen as **your** group health plan **claims administrator**.

This **plan booklet** describes benefits effective January 1, 2003, or the date after that on which **your** coverage became effective.

It is important that **you** fully understand the benefits provided under this **plan**. Failure to use the benefits correctly may result in claims being denied.

Date Prepared: April 22, 2003
File No. 808115001

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Hospital Claims

If **you** or an **enrolled dependent** is hospitalized, in most cases, all **you** need to do is present **your** Regence BlueCross BlueShield of Oregon identification card to the admitting office. Most **hospitals** will bill the **claims administrator** directly for the entire cost of the **hospital** stay. The **claims administrator** will pay the **hospital** and send **you** copies of their payment record. The **hospital** will then bill **you** for any of the charges that were not covered by **your** Regence BlueCross BlueShield of Oregon benefits.

Sometimes, however, the **hospital** will ask **you**, at the time of discharge, to pay amounts that might not be covered by **your** benefits. If this happens, **you** are responsible for these amounts **yourself**. **The plan** will, of course, reimburse **you** if any of the charges **you** pay are covered under the plan.

If **you** or **your enrolled dependent** receives treatment in a **hospital** which will not bill the **claims administrator**, or in a **hospital** outside the **plan** service area, **you** will receive a bill. In order to claim **your** benefits for these charges, send a copy of the bill to the **claims administrator**, and be sure it includes all of the following information:

- the name of the enrolled person who was treated;
- **your** name and **your** group and identification numbers;
- a description of the symptoms that were observed or a diagnosis; and
- a description of the services and the dates on which they were given.

The same procedure should be followed with bills for **hospital** or **professional provider** care **you** receive outside the United States.

Professional Provider Claims

A **professional provider** may bill charges directly to the **claims administrator**. If not, **you** may send **professional provider** bills to the **claims administrator yourself**. Be sure the **professional provider** uses his or her billing form and includes on the bill:

- the patient's name and the group and identification numbers;
- the date treatment was given;
- the diagnosis; and
- an itemized description of the services given and the charges for them.